

**Facility:** Central State Hospital

**Type of Inspection:** Unannounced Snap Shot Inspection

**Purpose of Inspection:** Inspect General conditions at the Facility, Staffing Ratios,

**Date:** July 1, 1999 - 5:00 p.m.

**Inspection Activities:** The units in two buildings were toured. These were Building 94 and 93. Building 93 is the acute admissions building and contains three units. Building 94 is the psychosocial Rehabilitation building and contains two units.

**Areas of Review:**

Section One- General Conditions, building 94

Section Two- Staffing, building 94

Section Three-Patient Activity, building 94

Section Four-General Conditions, building 93

Section Five-Staffing, building 93

Section Six-Patient Activity, building 93

## **Section One General Conditions in Building 94**

### **1.1 Finding: Bathrooms in the multipurpose room in building 94 reeked of old urine and had unwiped feces on the underside of the toilet lid.**

**Background:** This bathroom is on a ward that is not currently used as a residential unit. Individuals from the forensics step-down program in Building 95 come over during the day for parts of their active treatment, and the residents of Building 94 use the room as a dining hall. The individual who pointed out these conditions stated that they often are unclean. No patients were on this unit at the time. Part of the problem may be limited use of the space making it a lower priority for housekeeping staff. Patients stated they did not want to get the housekeeping staff in trouble, indicating that there was too much for one person to keep up with.

**Recommendation:** Investigate the schedule and staffing issues around bathroom cleaning in this "multipurpose" unit.

## **Section Two**

### **Staffing in Building 94**

**2.1 Finding:** Staffing was generally adequate on the units of Building 94 this evening.

**Background:** This is a non-acute ward. Many of the patients have been hospitalized for prolonged periods of time. Ward 94-3 had 18 female patients. They had one RN, one LPN and 3 human service care workers (HSCW) present for evening shift. Ward 94-4 is a coed ward. This night there were 9 female and 20 male patients. For these 29 patients, there was one RN, 1 practical nurse B (PNB) and 4 human service care workers (HSCW).

**Recommendation:** Continue to monitor the appropriateness of this level of staffing. It may be helpful to attempt to maintain a census of 20 to 25 on both of these units.

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**2.2 Finding:** Morale is marginal for both patient and staff associated with this unit.

**Background:** On the day of this inspection, patients had recently started going over to psychosocial rehabilitation at a different building. This represents a change that also requires staff to go with patients to the rehabilitation program. Both staff and patients feel this will be positive, but adjusting to the change is a new stress. Many of the patients on this unit are "stuck" and not clearly motivated to actively participate in their treatment. Some are patients who have been determined by the court system to be "Not Guilty by Reason of Insanity" (NGRI). Many of these individuals are waiting release by the external review board, and do not have active treatment issues. Additionally, many of the patients are suffering with major mental illness that are associated with amotivation. Technically this is referred to as the negative symptom complex, and can be seen with several major mental illnesses. This can be both a rewarding, and also very difficult population with which to work.

The amount of over-time on this unit is not as problematic as it is for some of the other more acute units. Staff has endured many changes over the last several years. These have included factors external to the unit such as changes in departmental and facility leadership as well as serious negative publicity about the place they have chosen to work. Internal to the unit, significant changes have occurred. These include a change in patient

population as well as the development of the off-ward psychosocial treatment programs.

**Recommendation:** Address morale on this unit. A performance Improvement Team with a focus on morale for Building 94 might be helpful. The team could have members from the facility director's office as well as Building 94 staff and patients.

### **Section Three**

#### **Activity of Patients in Building 94**

**3.1 Finding:** The patients in Building 94 were involved in various social activities in the day room of each unit.

**Background:** At the time of the inspection, patients had just eaten. Many of them will be going over for an evening program in the psychosocial rehabilitation center. Given the time of day, the activity level of these patients was appropriate.

**Recommendation:** None.

#### **IV. General conditions in Building 93**

**Finding:** Each of the unit day rooms was generally clean and appropriate, although very institutional in appearance.

**Background:** The units in this building consist of newly admitted patients. Thus one would expect to see more clinically unstable patients. At this time, patients on these units came predominantly from other acute care hospitals, this typically means that funding was unavailable to keep someone at the acute care hospital, or that the patient was unable to be stabilized after a reasonable amount of time in the acute care hospital. Some of the patients on the units in building 93 come directly from the community. The patients did not complain about housekeeping on these units. Several bathrooms in this building were reviewed, and were generally clean and appropriate. Unit 2, the female unit was much less institutional in appearance than the other two units in this building.

**Recommendation:** Investigate ways to have these units look less institutional.

#### **V. Staffing in Building 93**

**Finding:** Staffing was very marginal on each of these Units.

**Background:** Since mid-June, the Nursing Coordinator of this building has made a commitment to keep staffing at a minimum of four staff per ward all the time. This minimum was met, however, given the acuity of some of these patients, more RN staff clearly would have been beneficial. Ideally, a good experienced psychiatric RN can bring administrative and nursing assessment skills to a unit as well as modeling and providing actual support and treatment of patients on a unit. Although the minimal requirement of one RN per unit per shift was met this evening, the nurses were simply too busy reacting to mini-crises and doing required nursing documentation, to spend any meaningful time with patients or other staff.

The details of staffing were as follows: Unit 4, for 16 patients, had one RN, one Licensed Practical Nurse (LPN), and two Human Service Care Workers (HSCW). No patients were on 1:1 status. Unit 1 had 21 patients. For these patients there was 1 RN, 1 LPN, and 2 HSCW's. None of these patients were requiring 1:1 monitoring, but several were at high risk for escape, homicide risk and violence. These were on a status requiring every 15 minute checks and documentation. Unit 2 had 21 female patients. This unit had one RN and three HSCW staff. Two other HSCW staff were assigned, one to perform continuous 1:1 monitoring of a patient, and another to sit 1:1 with a patient on special hospitalization at an outside medical hospital for an acute medical problem. At least two of the HSCW staff were staying over from having worked an 8 hour shift immediately prior to this one.

Nursing staffing is an ongoing problem of great significance at Central State Hospital. There are problems with recruiting and with retaining qualified staff. This is in the face of a possible national nursing shortage. A long range plan needs to be developed to address this concern. One possibility is the consideration of further permanent reduction in the civil patient census. This could be done in a number of ways: more PACT teams in the CSH catchment area, redefinition of current catchment areas such that other facilities that do not have this problem are used for some patients, diversion funding for acute admissions or a contract to move a whole civil unit into a community hospital like the riverside forensics unit.

**Recommendation:** This ongoing problem should be reviewed. A long-term plan for Nursing Staffing problems at CSH should be devised.

## **VI. Activities of Patients in Building 93**

**6.1 Finding:** A patient was placed in restraints during the inspection. Observation of this event raises concern that the treatment culture at CSH is still using restraints inappropriately.

**Background:** While on Unit 2, a female patient was being placed in restraints. This patient had impulsively attempted to hit one of the staff. Staff present felt

that they had no other alternatives and that the patient needed to have a consequence for this activity. The patient was not visibly traumatized by this event. She knew what to expect because of previous experience with similar restraint episodes. She was compliant with application of the restraint bands. Staff appropriately adjusted the left wrist restraint when she felt it was too tight. The patient's history is long and complex. She has a previous history of hurting staff and patients when impulsively angry, and has difficulty learning new behaviors.

There were several issues that were concerning about this event. The patient did not seem to be learning from the event. In fact, the scenario of having several staff gathered around the bed working intensely with her while she was cooperating was probably reinforcing to this behavior. The staff did not seem to have a clear understanding of alternative interventions for this patient. The use of restraints was not in the treatment plan for this patient, but the treatment plan did not contain useful strategies for this recurring behavior. This patient would benefit from a special tailor-made behavioral plan designed to provide directives for staff when her behaviors occur. If the unit treatment team is unable to create a treatment strategy that works, the special Behavioral Consult team should be called in. By the time this patient was being put into restraints, she had regained internal control.

The problem here was not with the individual staff present that shift. Given their understanding of the situation, they were doing what they felt was right for this patient and the other patients on the unit. The problem relates more of lack of sophisticated clinical supervision and creation of a treatment culture that correctly uses seclusion, and especially restraint as a drastic last resort in emergencies that can not be addressed any other way. The staff who actually provide treatment nights and weekends need more contact with administration, supervisors and the day treatment teams.

**Recommendation: Clinical staff needs further mentoring and training in the use of restraint in emergency situations only.**

**6.1 Finding: The patients on all three units in building 93 were engaged in a variety of unit activities that appeared to be appropriate given the time of day.**

**Recommendation: None. This will be reviewed in future inspections.**